Administrative Policies and Procedures: 20.56

Subject:	**Child/Youth Death Internal Review**
Authority:	TCA 73-5-106
Standards:	DCS 2-101 A, 2-305, 7-200 A, 7-205 A,

Policy Statement:

The Department of Children's Services (DCS) shall conduct a comprehensive, multidisciplinary forensic review of the circumstances surrounding the death of a child/youth in custody or during an active Child Protective Services (CPS) investigation at the time of death.

Purpose:

DCS strives to improve its service to children and families through internal monitoring and when necessary, practice modification. The findings from these reviews will be used to improve the delivery of services to children, youth and families, to improve the health and safety of our children and youth, and to take action that may prevent other deaths in the future.

Procedures:

A. Initial Report	When a death of a child/youth in custody occurs, a **Notice of Child Fatality/ Near Fatality**, ***form CS-0635***, will be filed according to procedures outlined in the Incident Reporting Manual. A copy of **form CS-0635** will be forwarded to the Director of Medical and Behavioral Services. In cases where there is an active Child Protective Services (CPS) investigation, a copy shall also be forwarded to the Director of Child Protective Services following procedures outlined in *DCS Policy 14.20, Child Protective Services Child Death/Serious Injury Notification.*
B. Initial Program Review	1. When a death of a child/youth in custody occurs, a **Notice of Child Fatality/ Near Fatality**, ***form CS-0635*** will be filed according to procedures outlined in the Incident Reporting Manual. 1. The Family Service Worker (FSW), in collaboration with the Regional Health Nurse (RHN) or the Youth Development Center (YDC) Residential Case Manager, in collaboration with the YDC Health Care Administrator (for a child placed in a YDC), must prepare a detailed written summary of the circumstances surrounding the death for presentation to the Child Death Internal Review Team, as outlined in DCS *Policy 20.29, Death of a Child/Youth in DCS Custody/Guardianship*, to the Director of CPS. 2. The CPS Director or designee will gather pertinent documents related to the case including TNKids recordings, file documentation, medical records,

	autopsy reports, etc. and disseminate the information to appropriate staff. The initial review meeting will be scheduled as soon as all pertinent information is gathered not to exceed 60 days. ♦ Reviews must not be delayed due to pending Autopsy reports. 3. The DCS Team Leader and FSW will conduct an initial review of the case and will include the following participants as appropriate: a) Resource Family b) Community Residential Staff c) Private Provider Agency Staff d) Team Coordinator e) Youth Development Center Staff f) Child Protective Services g) Special Investigations Unit Staff h) Regional Health Unit Psychologist i) Regional Juvenile Justice Psychologist j) Regional Health Nurse k) Or YDC Health Administrator 4. Central Office staff may be designated by expertise or specialty to participate in this working review. 5. The charge of the initial review process will be to: a) Determine if all necessary information is available; b) Request any further information needed; c) Record statements from DCS staff, Private Provider Agency staff and resource family members involved with the child/youth about the event; and d) Determine if policies and procedures were followed.
C. Interdisciplinary Child Death Review Committee	1. Following the initial program review, an interdisciplinary Child Death Review Committee will review the child death case. This review will be scheduled after the initial review process and within 30 days of receipt of the autopsy report. The committee will have representatives from the following areas: a) The Director of CPS will chair the committee, b) Special Investigation Unit Representative c) Regional Health Unit Nurse and/or DCS Psychologist, d) Director of Medical and Behavioral Services, e) General Counsel or designee, f) Internal Affairs,

	g) Commissioner's Representative, h) Child Placement and Private Providers (as appropriate), i) Continuous Quality Improvement/Quality Assurance Representative, j) Foster Care Representative (as designated), k) Juvenile Justice Representative (as designated), l) Regional Juvenile Justice Psychologist (as appropriate) m) Regional DCS Team Coordinator, and n) Other relevant DCS staff as determined by the Committee 2. The charge of the Child Death Review Committee will be to: a) Allow members to share information from different perspectives, b) Identify the causes and circumstances of the child's death and to assess if anything could have been done to prevent the death, c) Determine if DCS staff and/or private provider staff followed appropriate policies and procedures, d) Develop recommendations for modification of policies, procedures or programs to improve services, e) Identify staff training or technical assistance needs, f) Identify specific barriers and system issues that may have contributed to the event, and g) Identify significant risk factors and trends in child death.
D. Committee Reports	1. After reviewing the case, the Child Death Review Committee will compile a report with concerns and recommendations, including time frames, for any corrective or improvement actions to the Commissioner, appropriate Deputy Commissioner, and Core Leadership Team. 2. The applicable program staff will provide a response regarding the recommended actions to the Committee Director who will provide follow-up information to the Committee, the Commissioner, and the appropriate Deputy Commissioner and Core Leadership Team.
E. Annual Child Death Review Committee Report	The Committee will compile an annual report on the causes of child/youth deaths and disseminate the report to the Commissioner, Deputy Commissioners, and Executive Directors.

Forms:	**CS - 0635 Notice of Child Fatality/Near Fatality**
Collateral Documents:	Incident Reporting Manual for Contract Agencies, DCS Foster Care and CPS http://www.state.tn.us/youth/policies/Chapter%2001%20Administration/Incident%20Reporting%20Manual%20for%20Contract%20Agencies%20DCS%20Foster%20Care%20and%20CPS.pdf Incident Reporting Manual for YDCs and DCS Group Homes http://www.state.tn.us/youth/policies/Chapter%2001%20Administration/Incident%20Reporting%20Manual%20for%20YDC%20and%20DCS%20Group%20Homes.pdf